



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON HOSPITAL FOR SPECIALIZED SURGERY
5445 LA BRANCH ST
HOUSTON TX 77004-6835

Respondent Name

AMERICAN ZURICH INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1958-01

MFDR Date Received

February 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied for no authorization. This was an emergency surgery due to an injury to the right index finger."

Amount in Dispute: \$4,572.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The outpatient procedure required preauthorization, and yet preauthorization was not sought or received. While the requestor has alleged that the surgery, performed one week after the date of the injury, was done on an emergency basis and did not require preauthorization, the requestor has provided inadequate documentation explaining the emergent nature of the procedure such that preauthorization was not required. Thus, no reimbursement is due at this time."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|--------------------|------------------------------|-------------------|------------|
| September 28, 2011 | Outpatient Hospital Services | \$4,572.46 | \$4,572.46 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

4. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 19 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.

Issues

1. Was preauthorization required for the disputed services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied payment for the disputed services with reason codes 19 – “(197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.” Per 28 Texas Administrative Code §134.600(c) "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." 28 Texas Administrative Code §133.2(3)(A) defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the submitted information finds documentation to support that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of a body part— including documentation of the risk of infection, the risk of callus formation obstructing reduction, and risk of permanent loss of function should stabilization have been delayed. As a medical emergency is supported, preauthorization was not required. Consequently, the insurance carrier's denial reason is not supported. These services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 26746 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0062, which, per OPPS Addendum A, has a payment rate of \$1,828.95. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,097.37. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted

labor-related amount of \$1,086.62. The non-labor related portion is 40% of the APC rate or \$731.58. The sum of the labor and non-labor related amounts is \$1,818.20. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$1,818.20. This amount multiplied by 200% yields a MAR of \$3,636.40.

- Procedure code 26418 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0053, which, per OPPS Addendum A, has a payment rate of \$1,182.20. This amount multiplied by 60% yields an unadjusted labor-related amount of \$709.32. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$702.37. The non-labor related portion is 40% of the APC rate or \$472.88. The sum of the labor and non-labor related amounts is \$1,175.25. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple-procedure discount, is \$587.63. This amount multiplied by 200% yields a MAR of \$1,175.26.
 - Procedure code 11012 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0019, which, per OPPS Addendum A, has a payment rate of \$350.49. This amount multiplied by 60% yields an unadjusted labor-related amount of \$210.29. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$208.23. The non-labor related portion is 40% of the APC rate or \$140.20. The sum of the labor and non-labor related amounts is \$348.43. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple-procedure discount, is \$174.22. This amount multiplied by 200% yields a MAR of \$348.44.
5. The total allowable reimbursement for the services in dispute is \$5,160.10. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$4,572.46. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4,572.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$4,572.46, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

November 16, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.